BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF WASHINGTON

In the Matter of THE APPLICATION REGARDING THE CONVERSION AND ACQUISITION OF CONTROL OF PREMERA BLUE CROSS AND ITS AFFILIATES	No. G02-45 PRE-FILED RESPONSIVE TESTIMONY OF SANDRA S. HUNT

I, Sandra S. Hunt, do hereby declare that the following facts are personally known to me and, if called upon to do so, I would testify to them.

1. I reviewed the pre-filed direct testimony and reports presented by Premera and offer responsive testimony related to the reports, supplemental reports, and pre-filed testimony of Brian Ancell, Heyward Donigan, Audrey L. Halvorson, Brian Kinkead, Jerry Lusk, Kent S. Marquardt, and Thomas McCarthy. The arguments made in the reports and testimony are similar to or depend upon one another. Consequently, these comments respond to the themes raised in the aggregate in Premera's presentations.

2. Thomas McCarthy bases his arguments regarding the competitiveness of the insurance markets in Washington on the theory that there is one single market for insurance for the entire state, ignoring stratification of the market by geography and product (i.e., individual, small group, mid-size group, large group, public programs, and so on.) Others rely on his arguments to reach conclusions in their testimony. This

argument belies the fact that insurance coverage is purchased at the local level and is refuted by the state's own mechanisms for regulating the markets. Washington, similar to all other states, separately regulates insurance products and pricing methodologies for products sold to individuals and to small groups, with strict regulation of small group pricing methodologies and community rating requirements for individual products.[1]. This distinction is made in regulation in recognition of the difference in risk mix and pricing power for these consumers versus those covered by large groups. The argument is also refuted by a review of insurance carrier participation in different markets. Many of the national insurers do not offer products in the individual and regulated small group markets, or participate in the public programs. Further, insurance coverage options vary significantly by geography. For example, CIGNA reports enrollment only in the large group market. PacifiCare operates in 8 counties in Western Washington and has insignificant membership in the individual and small group markets[2] Similarly, Aetna's HMO and POS enrollment is in the Western counties and is concentrated in the large group market. As shown by PricewaterhouseCoopers LLP (PwC) Exhibit "S-20", Chapters 5, 7 and 9, there is significant difference in the range of options available to consumers in eastern versus western Washington, and Premera's share of the market varies significantly in those geographies. Premera holds a market share of 27.6% in the western Washington small group market and a share of 87.6% in eastern Washington, even including those counties where Premera is not the exclusive

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[1] Relevant statutory provisions are found in chapters 48.43, 48.44, and 48.46, RCW.

[2] Form B enrollment reports for PacifiCare in CY 2003 showed statewide enrollment of about 100 individual members and 5,200 small group members, with a total of approximately 63,000. Spokane enrollment for all lines of business was reported as a monthly average of six members, all in large group.

holder of the Blue Cross and Blue Shield service mark. This relative market share level has been maintained for at least the past 10 years.[3] This market share advantage extends to Premera's role in contracting with providers. Indeed, providers in some areas of eastern Washington who choose not to contract with Premera have few commercial options remaining. Dr. McCarthy cites the availability of contracting with Medicare and Medicaid as viable alternatives to contracting to provide services to commercial insurance members. These public programs pay providers at fixed fee schedules and provide little latitude in contracting arrangements. Consequently, they are not reasonable substitutes for commercial insurance contracts.

3. Because Dr. McCarthy incorrectly defines the market for health insurance in Washington, conclusions that rely on that definition are meaningless. Similarly, conclusions made by others that rely on Dr. McCarthy's analysis are without merit.

4. Dr. McCarthy provides documentation in his report regarding the entry and exit of health plans in Eastern Washington to support his argument that the market is competitive. In so doing he incorrectly identifies plans entering the market and fails to note that the entry of several plans is limited in scope or is a result of a merger or purchase. The following table provides commentary on the health plans that have entered eastern Washington in the past five years and their enrollment growth during that time period. This pattern illustrates that, while a number of plans have entered the eastern Washington market, they have been largely unsuccessful in moderating Premera's role in the market.

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[3] For purposes of this discussion we have included Medical Services Corporation membership in the calculation.

Commentary on Health Plans Expanding into Eastern Washington 1995-2003

Adapted from Table 3 NERA report: List of Health Plans Expanding into Eastern or Western Washington, 1995-2002

Year	Parent Name	Plan Name	Change
1995	King County Medical, now DBA under Regence	Walla Walla Valley MSC	Acquisition of county Medical Society Plan
1998	Blue Cross Washington Alaska, now DBA Premera	Eastern Medical Services Corp	Merger gained Blue Shield mark in 14 counties in Eastern WA
1998	First Choice	First Choice Health Network	Eastern Washington - Now Network Rental Only
2003	First Choice	First Choice Health Plan	First Choice Health Plan has withdrawn all large and small insured health plan products from Washington State effective 12/31/03
1998	Regence	Regence NorthWest Health, now DBA Asuris	Eastern Washington - Reported enrollment of 9,400 in CY1998. Enrollment for CY2003 was 29,000, a 5-year increase of approximately 4,000 per year.
1998	NYLCare	NYLCare Health Plans NorthWest	Eastern Washington - Acquired by Aetna July 1998; Primarily public program enrollment (Medicaid and BHP) Aetna has minimal commercial enrollment in Eastern Washington; Reported less than 300 average monthly members in Spokane County for CY 2002.
1998	Group Health	Group Health Northwest	Merger; Group Health NW operated in 15 Eastern WA counties and parts of 3 others within a 70 mile radius of downtown Spokane.

2000	Group Health	Group Health Cooperative	Eastern Washington - Kittitas, Walla Walla and Whitman This is part of the takeover of Group Health NW in 1998. Operates in 8 counties in Eastern WA (plus 3 partial) Still in the expansion counties, but has withdrawn from other counties in Eastern Washington. Group Health NW no longer operates in the Eastern Central counties, including Chelan. Douglas, Grant, Okanogan and Ferry.
2001	Group Health	Group Health Cooperative	Eastern Washington - Columbia This is part of the takeover of Group Health NW in 1998. Operates in 8 counties in Eastern WA (plus 3 partial) Still in the expansion counties, but has withdrawn from other counties in Eastern Washington

5. Mr. Ancell and Mr. Donigan also comment on ease of entry of health plans into eastern Washington and state that the availability of rental networks proves that carriers can readily enter the market. Neither Mr. Ancell nor Mr. Donigan acknowledge the cost of renting a network and the effect of those costs on premium rates. Ancell notes that CIGNA rents the First Choice network and comments that this fact proves carriers can be competitive using rental networks. He fails to note that CIGNA lost membership between CY 2002 and CY 2003[4] and holds less than 3% of

[4] CIGNA average monthly enrollment dropped from approximately 103,000 in CY 2002 to 97,000 in CY 2003 based upon Form B enrollment filings with the Washington State Office of Insurance Commissioner.

the market and no membership in the individual and small group markets at all. These market share values suggest that CIGNA has not become an important competitor through the use of a rental network.

6. Mr. Ancell states on page 4 of his pre-filed direct testimony that Washington regulations require that health plans comply with network adequacy standards that are filed with the Washington State Office of Insurance Commissioner (OIC). He fails to include in his testimony the fact that each health plan determines its own network adequacy standards to meet the undefined criteria of "sufficient for timely access to appropriate health care", as stated at RCW 48.43.500, 510 and 515, and under WAC 284-43-200. Because health plans establish their own network adequacy standards, which are then enforced by the OIC, PwC requested assurances that Premera would not change the standards it currently has in place for its Heritage network, and further requested clarification that the assurance that the standards would not be reduced extend to all Premera PPO networks.

7. Ms. Halvorson makes several statements in her pre-filed direct testimony that require response. She states that the Economic Impact Assurances provided as part of the amended Form A should eliminate the concerns raised by PwC regarding premium rate increases in excess of health care cost trends in Premera's regulated individual and small group lines of business in the eastern portion of Washington. In its supplemental report, PwC states that the assurances mitigate the concerns, and that the probability of extraordinary rate increases is reduced. PwC does not state that the possibility of extraordinary rate increases within the time period of the assurances is eliminated.

8. Ms. Halvorson criticizes PwC's use of data that is more current than the Form A filing for the analysis of likely changes in Premera's financial performance. The Form A filing is nearly two years old, and Premera has provided during the process of this review updated financial information documentation. PwC believes the most current information available regarding Premera's financial performance should be used to assess the potential economic impact of the proposed conversion. Consequently, Ms. Halvorson's statement that the PwC conclusions regarding required premium rates increases to meet operating target goals are in error are not supported.

9. Mr. Lusk provides a detailed analysis of average premium rates pre and post conversion in the Milliman reports. The analysis is aggregated across all product lines and geographies. Because health insurance is purchased based on geography, product, and group size, this analysis provides no meaningful information regarding expected changes in premium rates post conversion. He relies on Dr. McCarthy's definition of a competitive market in Washington to reach conclusions regarding likely premium rate changes. As described above, Dr. McCarthy's definition of the Washington insurance markets is incorrect and conclusions based on that definition are equally incorrect.

10. Ms. Halvorson comments that PwC has not described how or whether Premera will have the ability to increase premiums in line with the calculations performed in Chapter 9 of Exhibit "S-20". In that chapter PwC demonstrates that premium rates would need to increase by as much as 9% for individuals and 4% for small groups in some areas of eastern Washington to reach Premera's statewide operating margin goals. Alternatively, costs would need to decrease. Ms. Halvorson states rate increases would not occur due to rating restrictions. The economic

assurances offered are intended to address the fact that the rating restrictions in current regulation would not protect consumers against rate increases of this magnitude. In the individual market in particular, Premera has the latitude to develop rates that vary geographically but cites its information systems limitations as a reason this latitude is not used. Providers in eastern Washington are paid less than providers in western Washington as illustrated in the area factors submitted with the small and large group rate filings [5] and have documented that the Premera physician reimbursement rates are substantially lower than those of Regence Blue Shield. Consequently, Premera could today change its premiums for individuals in eastern Washington. Further, Premera has a dominant market share in eastern Washington. Premera states that it believes the market in eastern Washington is competitive and that, despite its overwhelming share of the market, new offerings would become available if it raised its rates. Research on switching behavior shows that rate differentials of less than approximately 5% will be tolerated by enrollees of health plans. Thus, Premera has the regulatory ability to increase premiums and market ability to maintain its current membership at rates higher than those it currently charges in some markets. Significant changes in the insurance offerings in these areas would need to occur to threaten Premera's position in these markets.

[5] See Tables 6-3 and 6-4 in Exhibit "S-20" and documentation support submitted in connection with the NERA report, Bates number OICEXP_NERA02047.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated April 13, 2004 at San Francisco, California.

Sandra S. Hunt

SANDRA S. HUNT